Farmington Family Clinic
Washington Regional

Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Farmington Family Clinic as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Farmington Family Clinic to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize Farmington Family Clinic to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Farmington Family Clinic does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X_____

_____
(Patient or Parent/Guardian if under 18 years of age)

_____
Relationship of Guardian

_____
Date

PATIENT INFORMATION- PLEASE PRINT

Farmington Family Clinic
Washington Regional

SOC SEC #: _____-_____-_____ **MRN#:**_____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____**Ext:**_____

Address: _____ **Cell Phone:** _____

City: _____ **Date of Birth:** _____-____-_____ **Age:** _____yrs

State: _____ **Zip Code:** _____ **Employer:** _____

SEX: ☐ Male ☐ Female **Work Address:** _____

City: _____ **State:** ____ **Zip:** _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced
☐ Partner ☐ Widowed Separated **Occupation:** _____

Email:_____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐Return Patient/ Not Applicable
☐ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ **Cell:** _____

Employer: _____ **Work:** _____ **Ext:** _____

Work Address: _____ **Spouse/Parent SEX:** ☐ Male ☐ Female

City: _____**State:** _____ **Zip:** _____ **Spouse/Parent Date of Birth:** _____/_____/_____

Occupation: _____ **Social Sec. #:** _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ **Cell Phone:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Relationship to Patient:** _____

PRIMARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

SECONDARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ **Myself** ☐ **Spouse** ☐ **Child** ☐ **OTHER:** _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

ID# _____ **Group #** _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth:** _____/_____/_____

Main Holder's Address: _____ **Main Holder's Soc Sec#:** _____-_____-_____

City: _____

State: _____ **Zip:** _____

GENERAL INFORMATION

Who is responsible for Payment?: ☐ **Myself** ☐ **Other:**_____ **(FILL OUT BELOW)**

Responsible Party Name: _____ **Responsible Party DOB:** _____/_____/_____

Relationship to Patient: ☐**Self** ☐**Spouse** ☐**Child** ☐**OTHER** **SS#**_____-_____-_____

Address: _____ **Phone#:**_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? ☐ **Yes** **No**

If Yes, When?:_____/_____/_____ **Where?:**_____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Preferred Language: ☐**English** ☐**Spanish** ☐**Marshallese** ☐**Arabic** ☐**DECLINE** **OTHER:** _____

Race: ☐ **White** ☐**African American** ☐ **Asian** ☐ **Native Hawaiian/Other Pacific Islander**
☐ **Native American Indian/ Alaskan** ☐**Hispanic** ☐**Unknown** ☐ **DECLINE**

Ethnicity (Origin): ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino** ☐**Unknown** ☐**DECLINE**

Preferred Communication Method: ☐**Print** ☐**Save to Flash Drive** ☐**DECLINE**

Wellness Reminders: ☐**Mail** ☐**Cell Phone** ☐**Home phone** ☐**Work Phone** ☐**DECLINE**

PREFERRED PHARMACY: _____ LOCATION: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ **Date:** _____/_____/_____

Signature (Patient or Parent/Guardian if minor)